Acacia Health – Child Naturopathic Intake and Consent Form.

GENERAL INFORMATION:

Date__________________ PHN#____________________ Blood type_____________________

Name____Birthdate______________Phone________________________

Address___________________________________City________________________Prov/State_______________________

Postal Code______________ Parent/guardian's name___________________________ Phone(home)_________________

Phone (work)_________________ Email _____________________________________Best time to call_______________

Occupation____ (full or part-time)

Other parent or guardian____ Phone (home)________________________

Emergency contact____________________________relation?__________________________Phone__________________

How did you hear about us?____

Please list below all other health professionals your child is currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, chiropractor, etc.)

____

____

CURRENT HEALTH CONCERNS:

What is your main reason for seeking naturopathic care for your child? If they have a specific health condition, please describe it in detail. When was the first time that you noticed the condition and describe any factors that you suspect may have played a role in its onset and its continuation?

____

____

How long has this been troubling your child?____________________

Has it been getting (better, worse, remaining the same) and for how long?

____

In order of importance, list other health concerns that are troubling your child:

1.) ____Since when? ____________

2.) ____Since when? ____________

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3.) ____Since when? ___________

Other concerns:____

List all medications, supplements, herbs and homeopathic medicines your child is currently taking. Include dosage and results:____

____

List any treatments your child has had for this condition (surgery, acupuncture, massage, etc.) and the results. Include dates:____

____

If your child has been treated homeopathically in the past, please list the remedies taken, at what dose (strength & frequency), and with what results:

____

____

YOUR CHILD'S HEALTH HISTORY:

Child's general state of health is (Circle): excellent good average fair poor

Prenatal History:

What was the level of health of both parents at time of conception? (circle)

Mother: poor fair good excellent

Father: poor fair good excellent

What was the state of health of the parent during the pregnancy?

Poor Fair Good Excellent

Was this a planned pregnancy? (yes / no) If not, what type of birth control was used? ____________________________

Did the mother have any of the following during pregnancy (circle):

trauma (any kind)	chicken pox	Toxoplasmosis	rubella (Germanmeasles)
Chlamydia	HIV	genital herpes	syphilis
strep infection	severe nausea	Hypertension	diabetes
hypothyroidism	hyperthyroidism	eclampsia	depression

Other:____

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List any supplements, medicines, herbal medicines and homeopathic medicines taken by the mother during pregnancy:____

____

What were the parents emotional states during pregnancy?:____

Natal History:

How / where was your child delivered? (circle)

home birth hospital birth vaginal delivery C-section breech head-first

Were there any interventions during the child's birth? (circle)

induction (any type) vacuum extraction forceps epidural pain control

Length of pregnancy in months:________ Length of labour in hours:_____________Birth weight:___________________

Parents age at birth:_______________APGAR score________________

List any complications not covered above:____

Neonatal History:

Did your child have any of the following in the first year of his/her life? (circle)

Birth defects	Anemia	Respiratory problems
Jaundice	Rashes	Allergies
Birth injuries	Convulsions	Ear infections
Colic	Lack of appetite	

Other:____

After the first year:

Childhood Illnesses (circle):

Chicken pox	Measles	Mumps	Impetigo	Diarrhea
Polio	Strep throat	Scarlet fever	Allergies	Eczema
Lice	Pink eye	Tonsillitis	Tuberculosis	Colic
Constipation	Pneumonia	Croup	Diaper rash	Vision loss
Asthma	Cradle cap	Nose bleeds	Hearing loss	Hypothyroidism
Bed wetting	Ear infections	Anemia	Hyperactivity	Chronic infection
Depression	ADD/ADHD	Autism	Cancer	Oral herpes
Crohn's disease	Ulcerative colitis	Hypoglycemia	Epilepsy	Hyperthyroidism
Diabetes	Warts	Heart disease	Heart attack	
Canker sores	Hypertension	Hepatitis	Whooping cough	
Mononucleosis	Diabetes	Rubella	Diphtheria	

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Please list the five most significant, stressful events in your child's life, from the most recent to the most distant. Are any of these situations continuing to impact his or her life? (If so place a star next to the event.)

1.) ______________________________ Date__________

2.) ______________________________ Date__________

3.) ______________________________ Date__________

4.) ______________________________ Date__________

Is your child currently working with a professional counsellor, psychologist, social worker, pastor, rabbi, psychiatrist, or other therapist?
(yes / no) Have they in the past? (yes / no) If so, when?______________________________

Previous surgeries and hospitalizations not mentioned above (include dates)______________________________

____

Does your child have any allergies to any drugs, herbs, foods, animals or other? (yes / no)
Please list:______________________________

NUTRITIONAL HISTORY:

Was your child breast fed? (yes / no) Until what age?________Any problems?______________________________

If formula was used, which one was it?______________________________Any problems?______________

Food Introduction:
Please list foods introduced, in the order of introduction, with age and any reactions you noticed.

Food Introduced	Age	Reaction
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Describe your child's typical daily diet:

____

What is your child's favourite food?______________________________Least favourite food?______________________________

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How much water does your child drink a day?____

Any problems with bowel movements? If so, describe:____

VACCINATIONS:

Please note next to each vaccination, when the shot was given and any reaction noticed:

MMR____

DPT____

Polio____

Hemophilus influenza B____

Hepatitis B____

Chicken pox____

Other____

GROWTH AND DEVELOPMENT:

Note age, in months, when your child started to:

Roll over__________Sit up_________Crawl__________Walk__________Talk___________

When did their first tooth start coming in?__________ Any problems?______________________

When was bladder control achieved?____________ Bowel control?_________________________

Has your child had problems with toilet training? (yes / no) Describe:______________________

Does your child have any speech problems? (yes / no)_________________________________

Does your child have any of the following habits? (circle)

bed rocking head banging thumb sucking tics breath holding nail biting

SLEEP:

Does your child have currently and/or in the past: (circle)

nightmares insomnia sleep walking bed wetting teeth grinding

FAMILY HISTORY:

Please list ages, health problems and if deceased, cause of death:

	Living (age)?	Health problems	Died (age)?	Cause
Parent(s)				
Parent(s)				
Siblings				

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Grandparent(s)				
Grandparent(s)				
Grandparent(s)				
Grandparent(s)				

What is your child's ethnicity? ____

Does your child have any blood relative who suffers/or who has suffered from: (circle)

allergies	Arthritis	asthma	cancer	diabetes
depression	Eczema	heart disease	genetic disease	hypertension
ulcers	Cataracts	thyroid disease	hypoglycemia	seizures
gonorrhea	tuberculosis	syphilis	schizophrenia	bipolar disorder
anemia	Stroke	sickle cell	Alzheimer's	

ENVIRONMENT:

Describe your child's current living arrangements:____

What are your child's main interests and hobbies?____

What does your child worry about?____

How often does your child exercise per week?________ What kind and for how long?______________________

Does your child have dietary restrictions; religious or ethical?______________________________________

What religion is your child?____

Is your child in daycare? (yes / no) How many hours of TV does he/she watch per day?____________________

How much time per day does your child spend playing video games or using the computer?__________________

To your knowledge, has your child ever been physically or sexually abused?____________________________

How long has your child lived at his/her present address?______________________________________

Where has she/he lived previously?____

Is the home damp or moldy? (yes / no) How is your home heated?_________________________________

Is your child exposed to second hand smoke? (yes / no)

What kind of drinking water does your child drink? (circle)

bottled water filtered water distilled water tap water

List any pets in the child's home:____

Does your child have any problems at school? If so describe:______________________________________

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Please feel free to comment on any other concerns in the space below. Thank you for taking the time to fill out this form. The information is extremely useful for developing an effective treatment plan for your child.

____

____

Consents for Care:

1.) Consent for treatment:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (NDs) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and conduct a screening physical examination. This may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required. Treatment may involve such interventions as Botanical Medicine, Traditional Chinese Medicine, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counselling, Psychological counselling, and Homeopathy.

I understand that I must inform the Naturopathic Doctor immediately of any disease process that I may be suffering from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or am breast-feeding.

I understand that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests. I understand that Naturopathic Medicine is not covered by MSP (Medical Services plan) and I will need to pay for my services.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this Naturopathic Doctor. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

☐ I agree

2.) Privacy and Sharing of Information:

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I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the physicians at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

☐ I agree

3.) Cancellation Policy:

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

☐ I agree

4.) Collaborative Health Approach:

To provide me with truly integrated medical care I hereby give my consent to share my file and/or my medical history and current treatment plan options with any other practitioner that I am currently seeing (or may be referred to see in the future) at Acacia Integrative Health Clinic for the sole purpose of improving my current health condition and/or to discuss current and/or future treatment options.

☐ I agree ☐ I Disagree

x

Signed Name: Date:
(Parent or Legal Guardian)

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